approved educational activities less any grants, specific donations, or reimbursements of tuition.

(18) "Hospital-based nursing facility" means a nursing facility, as defined in K.A.R. 30-10-1a, that is attached to or associated with a hospital.

(19) "Inadequate care" means any act or failure to act which may be physically or emotionally harmful to a recipient.

(20) "Level of care" means the type and intensity of services prescribed in the resident's plan of care as based on the assessment and reassessment process.

(21) "Mental illness" means a clinically significant behavioral or psychological syndrome or pattern that is typically associated with either a distressing symptom or impairment of function. Relevant diagnoses shall be limited to schizophrenia, major affective disorders, atypical psychosis, bipolar disorder, paranoid disorders, or schizoaffective disorder.

(22) "Mental retardation" means subaverage general intellectual functioning which originates in the developmental period and which is associated with an impairment in adaptive behavior.

(23) "Non-working owners" means any individual or organization having five percent or more interest in the provider who does not perform a resident-related function for the nursing facility.

(24) "Non-working related party or director" means any related party, as defined in K.A.R. 30-10-1a, who does not perform a resident-related function for the nursing facility.

(25) "Nursing facility (NF)" means a facility which:

(A) meets state licensure standards;

(B) provides health-related care and services, prescribed by a physician ; and

(C) provides 24- hours- per-day, seven- days-per-week, licensed nursing supervision to residents for ongoing observation, treatment, or care for long-term illness, disease, or injury.

(26) "Nursing facility for mental health" means a nursing facility which:

(A) meets state licensure standards; (B) provides structured mental health rehabilitation services, in addition to health-related care, for individuals with a severe and persistent mental illness; and

(C) provides 24-hours-per-day, seven-days-per-week, licensed nursing supervision. The nursing facility shall have been operating in accordance with a provider agreement with the agency on June 30, 1994.

(27) "On-going entity" means a change in the provider has not been recognized.

(28) "Organization costs" means those costs directly incidental to the creation of the corporation or other form of legal business entity. These costs shall be considered to be intangible assets representing expenditures for rights and privileges which have value to the business.

(29) "Owner and related party compensation" means salaries,

drawings, consulting fees, or other payments paid to or on behalf of any owner with a five percent or greater interest in the provider or any related party, as defined in K.A.R. 30-10-1a, whether the payment is from a sole proprietorship, partnership, corporation, or non-profit organization.

(30) " Owner" means the person or legal entity that has the rights and interests of the real and personal property used to provide the nursing facility services.

(31) "Plan of care for nursing facilities" means a document completed by the nursing facility staff, which states the need for care, the estimated length of the program, the methodology to be used, and the expected results for each resident.

(32) "Projected cost report" means a cost report submitted to the agency by a provider prospectively for a 12-month period of time. The projected cost report shall be based on an estimate of the costs, revenues, resident days, and other financial data for that 12-month period of time.

(33) "Provider" means the operator of the nursing facility specified in the provider agreement.

(34) "Recipient" means a person determined to be eligible for medicaid/medikan services in a nursing facility.

(35) "Related parties" refers to any relationship between two or more parties in which one party has the ability to influence another party to the transaction in the following manner:

(A) When one or more of the transacting parties might fail to

pursue the parties' own separate interests fully;

(B) When the transaction is designed to inflate medicaid/medikan costs ; or

(C) when any party considered a related party to a previous owner or operator, becomes the employee, or otherwise functions in any capacity on behalf of a subsequent owner or operator. Related parties shall include parties related by family, business or financial association, or by common ownership or control. Transactions between related parties shall not be considered to have arisen through arms-length negotiations.

(36) "Related to the nursing facility" means that the facility is significantly associated or affiliated with, has control of, or is controlled by the organization furnishing the services, facilities, or supplies.

(37) "Representative" means either of the following:

(A) a legal guardian, conservator, or representative payee as designated by the social security administration; or

(B) any person designated in writing by the resident to manage the resident's personal funds, and who is willing to accept the designation.

(38)"Resident assessment form" means the document which:

(A) is jointly specified by the Kansas department of health and environment and the agency;

(B) is approved by the health care finance administration; and

(C) includes the minimum data set.

(39) "Resident assessment instrument" means the resident assessment, resident assessment protocols, and the plan of care, including reassessments.

(40) "Resident day" means that period of service rendered to a patient or resident between census-taking hours on two successive days and all other days for which the provider receives payment, either full or partial, for any medicaid/medikan or non-medicaid/medikan resident who was not in the home. Census-taking hours shall consist of 24 hours beginning at midnight.

(41) "Resident status review" means a reassessment to identify any nursing facility resident who may no longer meet the level of care criteria and who could be placed in a less intensive level of care setting.

(42) "Routine services and supplies" means services and supplies that are commonly stocked for use by or provided to any resident. The services and supplies shall be included in the provider's cost report.

(43) "Sale-leaseback" is a transaction where an owner sells a facility to a related or non-related purchaser and then leases the facility from the new owner to operate as the provider.

(44) "Severe and persistent mental illness" means that an individual:

(A) meets one of the following criteria:

(i) the individual has undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime;

(ii) the individual has experienced a single episode of continuous, structured supportive residential care other than hospitalization for a duration of at least two months; and

(B) meets at least two of the following criteria, on a continuing or intermittent basis, for at least two years:

(i) the individual is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history;

(ii) the individual requires public financial assistance for out-of-hospital maintenance and may be unable to procure such assistance without help;

(iii) the individual shows severe inability to establish or maintain a personal social support system;

(iv) the individual requires help in basic living skills; or

(v) the individual exhibits inappropriate social behavior which results in a need for intervention by the mental health or judicial system.

(45) "Specialized mental health rehabilitation services" means one of the specialized rehabilitative services which provide ongoing treatment for mental health problems and which are aimed at attaining or maintaining the highest level of mental and psychosocial well-being. The specialized rehabilitative services include the following:

(A) crisis intervention services;

(B) drug therapy or monitoring of drug therapy;

(C) training in medication management;

(D) structured socialization activities to diminish tendencies toward isolation and withdrawal;

(E) development and maintenance of necessary daily living skills, including grooming, personal hygiene, nutrition, health and mental health education, and money management; and

(F) maintenance and development of appropriate personal support networks.

(46) "Specialized services" means inpatient psychiatric care for the treatment of an acute episode of mental illness.

(47) "Swing bed" means a hospital bed that can be used interchangeably as either a hospital bed or nursing facility bed .

(48) "Twenty-four hour nursing care" means the provision of 24-hour licensed nursing services with the services of a registered nurse for at least eight consecutive hours a day, seven days a week.

(49) "Working trial balance" means the summary from the provider's general ledger that was used in completing the cost report.

(b) This regulation shall take effect on and after January 1, 1997. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c, as amended by L. 1996, Ch. 229, Sec. 104; effective May 1, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended April 1, 1992; amended Nov. 2, 1992; amended Jan. 3, 1994; amended July 1, 1994; amended

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Sept. 30, 1994; amended Dec. 29, 1995; amended Jan. 1, 1997.)

30-10-15a. Reimbursement. Payment for services. (a) Providers with a current signed provider agreement shall be paid a per diem rate for services furnished to medicaid/medikan eligible residents. Payment shall be for the type of medical or health care required by the resident, as determined by the attending physician's or physician extender's certification upon admission, and the individual's level of care needs, as determined through assessment and reassessment. However, payment for services shall not exceed the type of care the provider is certified to provide under the medicaid/medikan program. The type of care required by the resident may be verified by the agency before and after payment.

(b) Payment for routine services and supplies, pursuant to K.A.R. 30-10-1a, shall be included in the per diem reimbursement and such services and supplies shall not be otherwise billed or reimbursed.

(1) The following durable medical equipment, medical supplies, and other items and services shall be considered routine for each resident to attain and maintain the highest practicable physical and psychosocial well-being, in accordance with the comprehensive assessment and plan of care, and shall not be billed or reimbursed separately from the per diem rate:

(A) Alternating pressure pads and pumps;

(B) armboards;

(C) bedpans, urinals, and basins;

(D) bed rails, beds, mattresses, and mattress covers;

(E) canes;

(F) commodes;

(G) crutches;

(H) denture cups;

(I) dialysis, including supplies and maintenance;

(J) dressing items, including applicators, tongue blades, tape, gauze, bandages, band-aids, pads, compresses, ace bandages, vaseline gauze, cotton balls, slings, triangle bandages, pressure pads and tracheostomy care kits;

(K) emesis basins and bath basins;

(L) enemas and enema equipment;

(M) facial tissues and toilet paper;

(N) footboards;

(O) footcradles;

(P) gel pads or cushions;

(Q) geri-chairs;

(R) gloves, rubber or plastic;

(S) heating pads;

(T) heat lamps and examination lights;

(U) humidifiers;

(V) ice bags and hot water bottles;

(W) intermittent positive pressure breathing (IPPB) machines;

(X) I.V. stands and clamps;

(Y) laundry, including personal laundry;

(Z) lifts;

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(AA) nebulizers;

(BB) occupational therapy;

(CC) oxygen masks, stands, tubing, regulators, hoses, catheters, cannulae, and humidifiers;

(DD) parenteral and enteral infusion pumps;

(EE) patient gowns, pajamas, and bed linens;

(FF) physical therapy;

(GG) restraints;

(HH) sheepskins and foam pads;

(II) speech therapy;

(JJ) sphygmomanometers, stethoscopes, and other examination equipment;

(KK) stretchers;

(LL) suction pumps and tubing;

(MM) syringes and needles, except insulin syringes and needles for diabetics that are covered by the pharmacy program;

(NN) thermometers;

(OO) traction apparatus and equipment;

(PP) underpads and adult diapers, disposable and non-disposable;

(QQ) walkers;

(RR) water pitchers, glasses and straws;

(SS) weighing scales;

(TT) wheelchairs;

(UU) irrigation solution, both water and normal saline;

(VV) lotions, creams, and powders, including baby lotion, oil,

and powders;

(WW) first-aid ointments and similar ointments;

(XX) skin antiseptics, including alcohol;

(YY) over-the-counter vitamins;

(ZZ) mouthwash;

(AAA) over-the-counter analgesics and antacids taken for the occasional relief of pain or discomfort as needed;

(BBB) laxatives;

(CCC) stool softeners;

(DDD) nutritional supplements;

(EEE) blood glucose monitors and supplies;

(FFF) extra nursing care and supplies;

(GGG) compressors;

(HHH) orthoses and splints to prevent or correct contractures;

(III) maintenance care for residentswho have head injuries ;

(JJJ) non-emergency transportation; and

(KKK) respiratory therapy.

(2) Urinary supplies. Urinary catheters and accessories shall be covered services in the medicaid/medikan program when billed through the durable medical equipment or medical supply provider. This expense shall not be reimbursed in the per diem rate of the cost report.

(3) Total nutritional replacement therapy. Total nutritional replacement therapy shall be a covered service in the medicaid/medikan program and billed through the durable equipment or

medical supply provider. Total nutritional replacement therapy expenses shall not be reimbursed in the per diem rate from the cost report.

(4) Each nursing facility shall provide at no cost to residents over-the-counter drugs, supplies, and personal comfort items which:

(A) are available without a prescription at a commercial pharmacy or medical supply outlet; and

(B) the facility provides as a reasonable accommodation for individual needs and preferences. Such over-the-counter products shall be included in the nursing facility cost report. A nursing facility shall not be required to stock all products carried by vendors in the nursing facility's community that are viewed as over-the-counter products.

(5) When the nursing facility participates in both medicaid and medicare, and medicaid is the only payor for occupational, physical, respiratory, or speech therapy, the cost of those therapies shall be determined as follows:

(i) compute the ratio of medicaid therapy units to the total therapy units provided to the nursing facility residents during the cost report period;

(ii) multiply the ratio of medicaid therapy units by the total reported therapy costs to determine the allowable medicaid portion of therapy costs; and

(iii) multiply the medicaid portion of the therapy costs by the ratio of total days to medicaid resident days to determine the

*Substitute pa[illegible] dated APR 2 1 1997

allowable therapy expenses for the cost report period.

(c) Each provider of ancillary services, as defined in K.A.R. 30-10-1a, shall bill separately for each service when the services or supplies are required. Payment for oxygen shall be reimbursed to the oxygen supplier through the agency's fiscal agent, or the fiscal agent may reimburse the nursing facility directly if an oxygen supplier is unavailable.

(d) Payment for specialized rehabilitative services or active treatment programs shall be included in the per diem reimbursement.

(e) Payment shall be limited to providers who accept, as payment in full, the amount paid in accordance with the fee structure established by the medicaid/medikan program.

(f) Payment shall not be made for allowable, non-routine services and items unless the provider has obtained prior authorization .

(g) Private rooms for recipients shall be covered when medically necessary or at the discretion of the facility, and the costs shall be reflected in the facility's cost report. If a private room is not medically necessary or is not occupied at the discretion of the facility, then a family member, guardian, conservator, or other third party may pay the difference between the usual and customary charge and the medicaid payment rate.

(h) This regulation shall take effect on and after January 1, 1997. (Authorized by and implementing K.S.A. 1995 Supp. 39-708c,

Substitute per letter dated APR 2 1 1997 w

as amended by L. 1996, Ch. 229, Sec. 104; effective May 1, 1985; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended July 1, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994; amended Dec. 29, 1995; amended Jan. 1, 1997.)